Williamson County Office:
8160 Express Drive
Marion, IL 62959-5817
Phone 618/993-8111
Fax 618/993-6455

FRANKLIN-WILLIAMSON BI-COUNTY HEALTH DEPARTMENT
www.bicountyhealth.org

Franklin County Office:
403 East Park
Benton, IL 62812-1920
Phone 618/439-0951
Fax 618/438-3005

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(This Authorization complies with HIPAA)

Printed name of patient (first, middle, last name)	**Birthdate (mm/dd/yyyy)**
Address (Street Address, City, State, Zip Code)	
Phone Number	**E-Mail**

Printed name of guardian or legal guardian (first, middle, last name)	**Relationship**

I hereby authorize any healthcare professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing hours, consumer reporting agency, employer, and family member to release all health information about me.

I give permission for Franklin-Williamson Bi-County Health Department to **mail** my medical records to the address list below (must be legal mailing address of self) OR also Franklin-Williamson Bi-County Health Department to release my medical records for **office pick up** to the following: self, parent of legal guardian.

Person to RELEASE information to (must be self, parent of legal guardian)
Address (Street Address, City, State, Zip Code)
Phone Number

Franklin-Williamson Bi-County Health Department has permission to send my medical records to the following medical office:

Medical Office/Medical Organization to RECEIVE information	
Address (Street Address, City, State, Zip Code	
Phone Number	**Fax Number for Medical Offices**

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.
The following health information that relates to service(s) beginning, _____,
And ending_____, may be released.

I further understand that my medical record may include one or more of the following:

- TB infection & TB Disease medical records
- Communicable Disease medical records
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I understand and agree that the health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

This authorization is valid for 24 months following the date of my signature shown below. A copy, electronic copy, image or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is not effective to the extent the above person or organization has relied on the use or disclosure of my health information.

I have read (or have had read to me) this authorization, and I agree to tis terms as indicated by my signature below. I am entitled to a copy of this authorization.

Signature of Patient/Parent/Legal Guardian	Date Signed	Relationship if other than patient